

CONTINUING EDUCATION "PROVIDER" APPLICATION

Provider Name: _____

Provider #: _____
For Departmental Use Only

FEIN: _____ - _____

Provider is::

☐ Statewide Agents Association

☐ Institution of Higher Learning

☐ Authorized Insurer

☐ Insurance Trade Association

☐ Bona Fide Education School

☐ Provider of Independent
Program of Instruction

☐ Approved Pre-licensing Provider

☐ Other (Describe): _____

General Information:

Mailing Address: _____
Street or P.O. Box City State Zip

Street
Address:

(if different) Street City State Zip

Telephone# (____) ____ - ____ - _____ (____) ____ - _____ Fax# (____) ____ - _____

Name of Provider Representative (Contact Person): _____
First Name MI Last Name

E-Mail Address: _____

WEB Address: _____

Courses to be offered:

☐ P & C

☐ Life

☐ Health

☐ Life & Health

☐ Bail Bond

☐ Course offered to general public

☐ Course offered only to employees of insurance agency

Signature of Authorized Continuing Education Provider Representative

Date: _____

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To complete the application process, the \$300 application fee must be included. Mail to:

State of Alabama Department of Insurance
Continuing Education Section
P O Box 303351
Montgomery, AL 36130-3351